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Office of Administrative Law Judges
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Issue Date: 23 April 2007

In the Matter of
Mr. R.C.C.,¹
Claimant

Case No.: 2005 BLA 5670²

V.

BUFFALO MINING CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances: Mr. S.F. Raymond Smith, Attorney
For the Claimant

Mr. Christopher Hunter, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER --
APPROVAL OF MODIFICATION REQUEST &
AWARD OF BENEFITS**

This matter involves a claim filed by Mr. R.C.C. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

¹Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

²Although this claim is designated with a case number associated with the “new” regulations which became effective January 2001, the adjudication of this modification is controlled by the “old” regulations since the modification relates to the underlying claim which was filed prior to January 2001.

Procedural Background

Initial Claim

Mr. C. filed his first application for black lung disability benefits on May 10, 1994 (DX 23-1³). The U.S. Department of Labor (“DOL”) granted benefits on March 2, 1995 (DX 23-24). Following the Employer’s appeal (DX 23-26), the Black Lung Trust Fund initiated benefits on March 9, 1995 (DX 23-27), and the case was forwarded to the Office of Administrative Law Judges (“OALJ”) on May 4, 1995 (DX 23-28). Administrative Law Judge Edward T. Miller conducted a hearing on July 24, 1997 in Madison, West Virginia. On November 24, 1997, Judge Miller denied the claim because although Mr. C. established the presence of simple pneumoconiosis, there was no evidence of complicated pneumoconiosis, and the pulmonary tests and preponderance of the medical opinion did not demonstrate that Mr. C. was totally disabled (DX 23-51). On December 17, 1997, Mr. C. filed a motion for reconsideration on the issue of complicated pneumoconiosis (DX 23-52). On January 8, 1998, Judge Miller issued a Decision and Order Denying Relief Upon Reconsideration, first acknowledging that the claim did contain some evidence of complicated pneumoconiosis, but then finding that the preponderance of the evidence in the claim was negative for complicated pneumoconiosis (DX 23-53).

Second (“Duplicate”) Claim

Initial Adjudication

On August 22, 2000, Mr. C. submitted his second claim for black lung disability benefits (DX 1). The DOL granted benefits on June 13, 2001 (DX 20). On July 31, 2001, the DOL notified Mr. C. that the Black Lung Trust Fund would begin payments (DX 21). On September 14, 2001, the District Director sent the claim to OALJ for a formal hearing (DX 24). Administrative Law Judge Robert J. Lesnick held a hearing on June 12, 2002 in Charleston, West Virginia. On January 22, 2003, Judge Lesnick denied benefits because although Mr. C. demonstrated simple pneumoconiosis that arose from his coal mine employment, that was not a material change in condition, and in light of the preponderance of the probative medical opinion and due to the invalidity of the pulmonary function tests, Mr. C. did not show that he was totally disabled (DX 38). On January 24, 2003, the Claimant filed a notice of appeal with the Benefits Review Board (“BRB”) (DX 39). On January 29, 2004, the BRB affirmed Judge Lesnick’s determination (DX 43).

Modification

On February 20, 2004, the Claimant requested modification of the denial of his benefits (DX 43). On March 11, 2004, the District Director issued a Proposed Order to Show Cause Granting Request for Modification (DX 45). On March 19, 2004 the Employer requested additional time to submit evidence (DX 47), which was granted on April 14, 2004 (DX 48). On November 29, 2004, the District Director granted Mr. C.’s modification based on chest x-ray

³The following notations appear in this decision to identify exhibits: DX – Director exhibit; EX – Employer exhibit; CX – Claimant exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

interpretations that showed complicated pneumoconiosis (DX 49). On December 2, 2004 and December 13, 2004, the Employer requested a hearing before OALJ (DX 51, DX 52). The District Director forwarded the claim to OALJ on March 1, 2005 (DX 54). Pursuant to a Notice of Hearing dated October 6, 2005 (ALJ I), I held a hearing on February 14, 2006 in Charleston, West Virginia with Mr. C., Mr. Smith, and Mr. Hunter present.

Evidentiary Discussion

At the hearing, I reserved ruling on the applicability of the 2001 amended regulations in this claim. TR. p.7-9. Both the Claimant and the Employer thought that the “old regulations” applied to Mr. C.’s claim. *Id.* The DOL promulgated amended regulations on December 20, 2000, which became effective on January 19, 2001. 20 C.F.R. Parts 718, 725, and 726 (2001). These regulations require, among other things, restrictions to the amount of evidence that is admissible in a black lung benefits claim, so their application can be decisive in a claim.

Upon review of the regulations, I note that 20 C.F.R. § 725.2(c) (2001) provides that the regulatory restrictions imposed by the new regulations do not apply to claims that “pending on January 19, 2001” Since Mr. C.’s duplicate claim had not been finally denied by January 19, 2001 and his modification request relates to the duplicate claim, consistent with the parties’ consensus at the hearing, that the new regulations do not apply. *See Gross v. Dominion Coal Corp.*, 23 B.L.R. 1-8 (2004) (discussing applicability of 2001 regulations).⁴

ISSUES

As will be fully discussed below, it is clear in light of recently-developed medical evidence that Mr. C. has complicated pneumoconiosis. Although the Employer did not stipulate to the entitlement issues, as discussed at the hearing,⁵ the essential issue in this claim is the date of entitlement for benefits. Because the mass in Mr. C.’s lungs has been identified convincingly as complicated pneumoconiosis, I will begin the adjudication of this modification by evaluating whether there was a mistake of fact that lead to the denial of benefits based on a different interpretation of the mass in Mr. C.’s lungs.⁶ Accordingly, the issues are:

1. Whether in filing a modification request on February 20, 2004, Mr. C. demonstrated that either: a) a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his second claim was based; or b) a mistake in determination of fact occurred in the denial of his second claim on January 22, 2003.

⁴At the same time, based on other provisions of 20 C.F.R. § 718.2 (2001), some portions of the new regulations apply to Mr. C.’s claim.

⁵TR. p.23-25.

⁶In his request for modification before the District Director, the Claimant argued that the determination that Mr. C. did not have pneumoconiosis was a mistake of fact. DX 43. Because Mr. C. was found to have simple coal workers’ pneumoconiosis, I infer that he alleges a mistake of fact in the complicated pneumoconiosis determination.

2. If Mr. C. establishes a change in condition or a mistake of fact, whether in filing his second claim on August 20, 2000, Mr. C. demonstrated a material change in condition since the denial of his first claim in January 1998.
3. If Mr. C. establishes a material change in condition, whether he is entitled to benefits under the Act.
4. The date of entitlement.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. C. was a miner with post-1969 coal mine employment, b) the length of his coal mine employment with Buffalo Mining Co. was at least 25 years, c) Buffalo Mining Co. the responsible operator in this claim, and d) Mrs. D.C. is a dependent (TR, p.10, 11, 21).

Preliminary Findings

Born on May 29, 1939, Mr. C. married Mrs. D.C. on June 6, 1994. Mr. C. worked for Buffalo Mining Co. for the bulk of his career. His last coal mine job was as a roof bolter, occasionally lifting 50 pound bags. Mr. C. worked in the Buffalo Mining mine in West Virginia until March 1993, when the mine closed down. As of February 2006, Mr. C. was unemployed. (DX 6, TR p.15, 18-19)

Issue # 1 – Modification

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310(a). Upon the showing of a “change in conditions” or a “mistake in a determination of fact” the terms of an award or the decision to deny benefits may be reconsidered. 20 C.F.R. § 725.310. An order issued at the conclusion of a modification proceeding may terminate, continue, reinstate, increase, or decrease benefit payments or award benefits.

According to the courts and BRB, the phrase “change in conditions” refers to a change in a claimant’s physical condition. *See General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982); *Lukman v. Director, OWCP [Lukman II]*, 11 B.L.R. 1-71 (1988). Under the regulatory provisions, to determine whether a claimant demonstrates a change in conditions, an administrative law judge (“ALJ”) must first conduct an independent assessment of all newly submitted evidence. Then, the ALJ must consider this new evidence in conjunction with all evidence in the official DOL record to determine if the weight of the evidence is sufficient to establish an element of entitlement which was previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R.

1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.*, 16 B.L.R. 1-71 (1992).

The modification process has been further expanded by the U.S. Supreme Court and federal Courts of Appeals when they considered cases involving the mistake of fact factor listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the U.S. Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." See also *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. [Cornelius]*, 831 F.2d 240 (11th Cir. 1987).

My determination of whether either a change in condition has developed or a mistake of fact occurred involves the four entitlement elements that a claimant must prove by a preponderance of the evidence to receive benefits under the Act. First, the coal miner must establish the presence of pneumoconiosis.⁷ Second, if a determination has been made that a coal miner has pneumoconiosis, it must be determined whether the coal miners' pneumoconiosis arose, at least in part, out of coal mine employment.⁸ If a coal miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.⁹ Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.¹⁰ Third, the coal miner must demonstrate total respiratory disability.¹¹ Fourth, the coal miner must prove the total disability is due to coal workers' pneumoconiosis.¹²

In Mr. C.'s first claim, he did not qualify for benefits because although he showed simple pneumoconiosis (not complicated pneumoconiosis), he did not show total disability. To prevail in his second claim, Mr. C. needed to show a material change in condition since the denial of his first claim in January 1998. The ALJ denied benefits in the second claim¹³ because although Mr. C. established simple pneumoconiosis this was not a change from the prior decision, and Mr. C. did not establish the presence of complicated pneumoconiosis or a totally disabling pulmonary impairment.

⁷20 C.F.R. § 718.202 (2001).

⁸20 C.F.R. § 718.203(a) (2001).

⁹20 C.F.R. § 718.203(b) (2001).

¹⁰20 C.F.R. § 718.203(c) (2001).

¹¹20 C.F.R. § 718.204(a) (2001).

¹²*Id.*

¹³The BRB affirmed this decision in January 2004.

In light of that procedural setting, I will first evaluate the entire record from Mr. C.'s duplicate claim to determine whether he is able to demonstrate that a mistake of fact occurred during Judge Lesnick's adjudication that lead to his January 22, 2003 denial of Mr. C.'s second claim. Secondly, if necessary, I will evaluate whether Mr. C. can show a change of conditions based on new evidence that he has become totally disabled due to a pulmonary impairment since the January 22, 2003 denial of his claim.

Mistake of Fact

To determine whether a mistake in a determination of fact occurred, an ALJ must review all of the evidence in the record, both old and new. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994). The alleged mistake of fact in this claim relates to whether the masses on Mr. C.'s lungs are complicated pneumoconiosis. Accordingly, I will review the evidence of Mr. C.'s duplicate claim to determine whether he has complicated pneumoconiosis.

Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304 (2001), provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established.

In the Black Lung Benefits Act, 30 U.S.C. 921(c)(3)(A) and (C), as implemented by 20 C.F.R. § 718.304(a) (2001), Congress determined that if a miner suffered from a chronic dust disease of the lung which "when diagnosed by chest x-ray, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C," there shall be an irrebuttable presumption that his death was due to pneumoconiosis.¹⁴ This type of large opacity is called "complicated pneumoconiosis." The statute and regulation also permit complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence. 30 U.S.C. 921(c)(3)(B) and (C) and 20 C.F.R. §§ 718.304(b) and (c) (2001). Additionally, a diagnosis of progressive massive fibrosis is consistent with a finding of complicated pneumoconiosis. The Supreme Court recognized complicated pneumoconiosis as "involv[ing] progressive massive fibrosis as a complex reaction to dust and other factors." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976). Moreover, the U.S. Court of Appeals for the Fourth Circuit commented that complicated pneumoconiosis is also known "by its more dauntingly descriptive name, 'progressive massive fibrosis'." *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1359 (4th Cir. 1996).

According to the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is

¹⁴On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes, identified by letters. Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

established by “congressionally defined criteria.” As a result, the statute’s definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921(c)(3)(A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921(c)(3)(B) and (C). *Scarbro*, 220 F.3d at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921(c)(3)(B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921(c)(3)(A).¹⁵ Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community’s definition of the disease. *Scarbro*, 220 F.3d at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated,

if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id.*

Referencing a 1993 Fourth Circuit case, *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993) the BRB in *Mullins v. Plowboy Coal Co.*, BRB No. 04-0716 BLA, (July 8, 2005) (unpub.) emphasized that an ALJ “must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis.” That mandate is consistent with other case law indicating that all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

In other words, even if the presence of large opacities is established through one of the three methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine whether the large opacities actually exist and involve pneumoconiosis. For example, the BRB affirmed a finding of complicated pneumoconiosis under § 718.304 when the ALJ considered chest x-rays in conjunction with CT scan results to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996). In another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under § 718.304 involves a three step process.

First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized

¹⁵See also 20 C.F.R. §§ 718.304(b) and (c) (2001).

standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities.

Second, if large opacities are established, I must also evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence demonstrates the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

1. Existence of Large Opacities

In the absence of biopsy evidence, Mr. C. must rely on chest x-ray imaging, or other medical tests or means to establish the presence of large opacities.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
October 10, 2000	DX 10	Dr. Ranavaya, B ¹⁶	Positive for pneumoconiosis, profusion 3/2, ¹⁷ type r/q opacities, ¹⁸ and category C opacity. Large conglomerate lesions that likely relate to overall fibrosis associated with progressive massive fibrosis or complicated coal workers' pneumoconiosis, but correlation and follow-up is recommended to rule

¹⁶The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202(a)(1)(ii) (2001).

¹⁷The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102(b) (2001), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

¹⁸There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, *RESPIRATORY DISEASES* 581 (3d ed. 1981). According to the ILO Form instructions, for a mixed group of shapes and sizes of opacities, the predominant shape and size is recorded first and the “presence of a significant number of another shape and size is recorded after the oblique stroke.”

			out any other progressive pathology.
(same)	DX 11	Dr. Binns, B, BCR	Positive for pneumoconiosis, profusion 3/+, type r/q opacities, type B large opacities.
(same)	DX 22	Dr. Scott, B, BCR	Positive for pneumoconiosis, profusion 3/3, type r/u opacities. No large opacities. "Much of the nodular infiltrate is peripheral and probably due to tb, unknown activity. Changes compatible with silicotuberculosis."
October 17, 2001	DX 29	Dr. Repsher, B	Positive for pneumoconiosis, profusion 3/3, type r/q opacities. No large opacities. Emphysema.
(same)	DX 27	Dr. Scott, B, BCR	Positive for pneumoconiosis, profusion 3/3, type r/r opacities. No large opacities. Small pleural effusions or fibrosis bilaterally. All of the changes could be "tb, but could also be silicotuberculosis." Peripheral masses in upper zones are more likely tuberculosis than conglomerate pneumoconiosis (large opacities).
February 11, 2004	DX 43	Dr. Aycoth, B ¹⁹	Positive for pneumoconiosis, profusion 2/2, type q/t opacities, and large category C opacity. At least two 3-4 cm masses, both upper lung zones. Complicated pneumoconiosis. Scattered rounded density opacities measuring up to 5 mm in diameter in both lungs. Pleural thickening along right lateral chest wall, 5-10 mm in width. Changes of COPD. Emphysema.
(same) ²⁰	DX 44	Dr. Binns, B, BCR	Positive for pneumoconiosis, profusion 3/3, type r/q opacities, and large category B opacity. Emphysema. Pleural thickening may be related to pneumoconiosis, but is not typical of what is seen with asbestosis.
February 23, 2005	EX 1	Dr. Zaldivar, B	Positive for pneumoconiosis, profusion 2/2, type r/q opacities, and large category C opacity. Emphysema.

There are three interpretations of the October 10, 2000 chest x-ray. Dr. Ranavaya, a B reader, found a category C opacity. Dr. Binns, a dual qualified radiologist, found type B opacities. Dr. Scott, also a dual qualified radiologist, disagreed and found no large opacity. Because the two better qualified radiologists, Dr. Binns and Dr. Scott, disagree about the presence of a large opacity in the October 10, 2000 chest x-ray, I find that it is inconclusive for the presence of a large opacity.

Neither interpretation of the October 17, 2001 chest x-ray found a large opacity, so I find that it is negative for the presence of a large opacity.

¹⁹I verified Dr. Aycoth's status as a B reader using the "Comprehensive List of NIOSH Approved A and B Readers," which can be found on the OALJ website, <http://www.oalj.dol.gov>.

²⁰This is a DOL re-read of the February 11, 2004 x-ray. I include this in the evidence summary because there is no limit to evidence that could be submitted on a pre-2001 modification.

Both interpretations of the February 11, 2004 chest x-ray found opacities greater than 1 cm in diameter. Accordingly, I find this x-ray to be positive for the presence of a large opacity.

Based on Dr. Zaldivar's uncontested February 23, 2005 chest x-ray, I find that x-ray is positive for the presence of a large opacity.

After setting aside the inconclusive image from 2000, the preponderance of the remaining three radiographic studies, represented by the 2004 and 2005 chest x-rays, is positive for the presence of a large pulmonary opacity.

2. Other Evidence of Large Opacities

CT Scan

Although the admissible chest x-ray interpretations in the record establish the presence of a large pulmonary opacity, I must also assess the other relevant evidence to determine whether it confirms or negates the radiographic finding of a large pulmonary opacity. In Mr. C.'s case, that potentially relevant evidence consists of the interpretations of Dr. Christopher A. Schlarb and Dr. George L. Zaldivar of a CT scan taken on February 23, 2005.²¹

Dr. Schlarb (EX 1), board certified in radiology,²² reviewed the CT scan. He observed multiple calcified mediastinal and hilar lymph nodes, aortic atherosclerosis, and coronary atherosclerosis. Bilateral mid and upper lobe masses were present with some calcification with multiple "large areas of nodular consolidation" as well as more focal areas of nodules scattered within the upper and mid lungs. Dr. Schlarb opined the "conglomerate masses" associated with nodular interstitial opacities were consistent with occupational pneumoconiosis. There was a small amount of scarring at both lung bases with scattered reticular nodular interstitial opacities present as well. The nodules were too numerous to count and malignancy could not be ruled out.

Dr. Zaldivar (EX 1), board certified in pulmonary diseases, internal medicine, sleep disorder, and critical care medicine, reviewed the CT scan.²³ The scan revealed the presence of "very large masses" in the upper and mid zones in both lungs with surrounding smaller nodular densities. The masses and the aorta contained calcification. There was evidence of bullae, which may be of traction emphysema. The scan was compatible with simple and complicated pneumoconiosis.

²¹In *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123 (2006) (en banc), the BRB held that "the use of singular phrasing in 20 C.F.R. § 718.107" requires that "only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence." *Webber* is a "new regulations" case that does not limit interpretations of CT scans in "old regulations" claims.

²²I take judicial notice of Dr. Schlarb's board certification and have attached the certification documentation.

²³Dr. Zaldivar's overall medical report identified the CT scan as dated March 23, 2005. In an interpretation dated March 7, 2005, Dr. Zaldivar identifies the CT scan as dated February 3, 2005. The initial CT scan report from the Charleston Area Medical Center was dated February 23, 2005. I find that Dr. Zaldivar's report contained mere typos and that these references are all to the same CT scan dated February 23, 2005.

Dr. Schlarb's finding of large areas of nodular consolidation and conglomerate masses, coupled with Dr. Zaldivar's observation of very large pulmonary masses, support, rather than contradict, the chest x-ray evidence of large pulmonary masses.

Medical Opinion

The preponderance of the physicians who assessed Mr. C.'s pulmonary condition since 2000, Dr. Ranavaya, Dr. Crisalli, Dr. Spagnolo, Dr. Hippensteel, and Dr. Zaldivar, did not dispute that he had a large pulmonary opacity or mass in his lungs. Their fundamental disagreement was the etiology of the opacity.

Conclusion

Accordingly, I find the additional medical evidence, consisting of the two interpretations of the February 23 CT scan and the preponderance of the medical opinion, supports a determination that the preponderance of the radiographic evidence establishes the presence of large pulmonary opacities in Mr. C.'s lungs.

3. Cause, or Etiology, of Large Opacities

Through the preponderance of chest x-ray evidence developed since August 2000, as supported by the February 23, 2005 CT scan, Mr. C. has shown the existence of a large pulmonary opacity. As a result, I move to the third adjudicative step and consider other relevant medical evidence on the cause of the opacities. Specifically, I will review all the medical evidence associated with the duplicate claim and the modification proceedings to determine whether the large pulmonary opacity is due to coal mine dust exposure or coal workers' pneumoconiosis.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre²⁴ post²⁵	FVC pre post	MVV pre post	FEV¹/FVC pre post	Qualified²⁶ pre post	Comments
DX 7	Oct. 10, 2000 Dr. Ranavaya	61 69"	2.09 2.18	2.67 2.78	40.7 50.4	78.3% 78.4%	No ²⁷ No	Invalid per Dr. Renn (DX 30)

²⁴Test result before administration of a bronchodilator.

²⁵Test result following administration of a bronchodilator.

²⁶Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

²⁷The qualifying FEV1 number is 1.95 for age 61 and 69."

DX 25	Oct. 17, 2001 Dr. Crisalli	62 71"	1.67 1.79	1.83 1.85	55 --	91.2% 96.8%	Yes ²⁸ Yes	Invalid per Dr. Renn (DX 30)
EX 1	Feb. 23, 2005 Dr. Zaldivar	65 69"	1.70 1.89	2.38 2.32	--- ---	71.4% 81.5%	Yes ²⁹ Yes	Valid test. moderate restriction

In regards to the one valid pulmonary function test, Dr. Zaldivar commented that Mr. C. had moderate restriction of vital capacity, mild restriction of total lung capacity, and severe diffusion impairment. In his opinion, this demonstrated pulmonary function test was consistent with the pulmonary impairment caused by advancing complicated pneumoconiosis.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ² (rest) pCO ² (exercise)	pO ² (rest) pO ² (exercise)	Qualified ³⁰	Comments
DX 9	Oct. 10, 2000 Dr. Ranavaya	42 39.0	65 71.6	No ³¹	
DX 25	Oct. 17, 2001 Dr. Crisalli	30 --	94 --	No ³²	
EX 1	Feb. 23, 2005 Dr. Zaldivar	42 --	81 --	No	

Although Mr. C.'s recent arterial blood gas studies were normal, non-qualifying arterial blood gas studies do not provide sufficient evidence standing alone to determine the pathology associated with the large opacity in his lungs. Additionally, Dr. Zaldivar opined that in light of the February 2005 pulmonary test results, an exercise arterial blood gas study may have established an oxygenation deficiency.

Medical Opinion

Dr. Mohammed I. Ranavaya
(DX 8)

On October 10, 2000, Dr. Ranavaya, board certified in occupational medicine,³³ evaluated Mr. C.'s pulmonary health. Mr. C. ran a pin machine for 27 years in the coal mines.

²⁸The qualifying FEV1 number is 2.09 for age 62 and 71"; the corresponding qualifying FVC value is 2.67.

²⁹The qualifying FEV1 number is 1.89 for age 65 and 69"; the corresponding qualifying FVC value is 2.42.

³⁰To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO² level, the value of the coal miner's pO² must be equal to or less than corresponding pO² value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

³¹For the pCO² of 40 to 49, the qualifying pO² is 60 or less.

³²For the pCO² of 30, the qualifying pO² is 70 or less.

³³I take judicial notice of Dr. Ranavaya's board certification and have attached the certification documentation.

Before that he ran a forklift and a punch press for 5 years for a manufacturing company. He last worked in 1993 when the mines shut down. Mr. C.'s history included wheezing in 1990, a heart attack in 1989, and rheumatic fever/heart murmur in 1953. Mr. C. smoked from 1967 to 1981, at the rate of one pack per week. Mr. C. complained of daily sputum, occasional wheezing, daily dyspnea, occasional chest pain, orthopnea, and paroxysmal nocturnal dyspnea. His shortness of breath occurred upon mild to moderate exertion, such as up 10 steps or walking 75-100 feet on level ground. Upon physical examination, Dr. Ranavaya heard a systolic heart murmur. Dr. Ranavaya diagnosed complicated coal workers' pneumoconiosis based on Mr. C.'s 27 years in the coal mines and radiographic evidence of complicated pneumoconiosis. Mr. C.'s pulmonary impairment was moderate, which would prevent him from performing his last coal mine employment on a sustained basis.

Dr. Robert J. Crisalli
(DX 25, DX 26, DX 31)

On October 17, 2001, Dr. Crisalli, board certified in internal medicine and pulmonary diseases, evaluated Mr. C.'s pulmonary health. Mr. C. worked in the coal mines for 30 years until 1993. In his last three years, he operated a pinning machine. Mr. C. smoked until 17 years ago, but he smoked half of a pack per day for about 22 years. Mr. C. complained of shortness of breath and productive daily cough. He had a myocardial infarction in 1989, rheumatic fever in the 8th grade, and a history of heart murmur. Mr. C. has been hospitalized several times for respiratory illnesses. Although Mr. C. said that he underwent an inconclusive biopsy in 1997, he declined the open biopsy recommended by his physician. Mr. C. took inhaled bronchodilators but did not use home oxygen. Upon physical exam, the chest wall motion was diminished and Dr. Crisalli heard decreased breath sounds. There were no rales, wheezes, or prolonged expirations. The cardiac exam revealed a systolic murmur. The chest x-ray was positive for coal workers' pneumoconiosis and class C opacities. The pulmonary function tests were invalid because of variable effort. Dr. Crisalli also reviewed medical evidence from Mr. C.'s black lung claims, dated 1977 to 2000.

Dr. Crisalli diagnosed simple coal workers' pneumoconiosis, lung mass, weight loss, coronary artery disease, and anemia. It is not medically reasonable to diagnose complicated coal workers' pneumoconiosis in this case, because the etiology of the larger densities is unknown. Malignancy is a possibility. Mr. C.'s simple coal workers' pneumoconiosis did arise from his exposure to coal dust. Whether Mr. C. has a significant pulmonary impairment is unknown because neither the 2001 nor the 2000 studies were valid. Mr. C. is unable to work in the coal mines again, but this is not due to his coal workers' pneumoconiosis; it is due to his weight loss and possible malignancy in his lung.

At a deposition on May 9, 2002, Dr. Crisalli indicated that Mr. C. was at risk for lung cancer because he was a smoker and was exposed to coal dust in the workplace. Reduced motion in the chest wall goes along with chronic lung disease, particularly emphysema. A finding of a "c" opacity is not necessarily a finding of a mass caused by coal dust exposure or occupational pneumoconiosis, it could be cancer. Dr. Ranavaya's pulmonary function test was invalid. In 1995, Mr. C.'s ventilatory function was valid and showed no obstruction or restriction, and his arterial blood gas normal. Dr. Ranavaya's 2000 arterial blood gas study was

not as good as it was in Dr. Crisalli's 2001 exam. Coal workers' pneumoconiosis is an irreversible fibrotic process, so you would not expect reversibility in the blood gas studies. Lung cancer or granulomatous disease, such as tuberculosis, fungus infection, and sarcoidosis can all cause "this type of large density to occur." Dr. Wheeler's report did not diagnose complicated coal workers' pneumoconiosis, but did diagnose lung masses either due to tuberculosis, sarcoidosis, histoplasmosis, or Weggener's granulomatosis. Dr. Crisalli said that the possibility that the density represented cancer was still a possibility in his mind. The masses identified in the x-rays are not consistent with complicated pneumoconiosis, and Mr. C. presented with considerable weight loss, which suggested lung cancer to Dr. Crisalli. Tuberculosis or a fungus infection was also possible. Someone might not know if they had "smoldering tuberculosis," and the granulomatous diseases can be smoldering too. There's no known association between Weggener's granulomatosis or sarcoidosis and coal dust exposure. Sarcoidosis, Weggener's, and infectious-type granulomatous disease are treatable. Weight loss is a common finding with granulomatous diseases. Even if lung cancer was ruled out, Mr. C. does not necessarily have complicated pneumoconiosis. Coal workers' pneumoconiosis can be progressive, but Mr. C.'s weight loss and the location of the lesions in all of Mr. C.'s x-rays are not in accord with complicated pneumoconiosis. There are a lot of lung diseases which can be latent and progressive. Mr. C. does have simple pneumoconiosis based on the chest x-rays, but based on the 1995 pulmonary exam he was not disabled at all, and Dr. Crisalli did not have a more recent, reliable set of pulmonary function test results. Dr. Crisalli could not make a diagnosis based on the more recent arterial blood gas studies alone. Mr. C. does not have any disability related to or even aggravated by coal dust exposure.

Dr. Paul S. Wheeler
(DX 28, DX 35)

On April 11, 2002, Dr. Wheeler, board certified in radiology, provided his overall interpretation of several of Mr. C.'s chest x-rays. The December 12, 1977 x-ray was normal, followed by a December 19, 1986 x-ray showing mixed linear and small nodular infiltrates or fibrosis in the upper half of both lungs with subtle adenopathy in the lower right hilum. This is very likely granulomatous disease such as TB or sarcoid but some nodules could be CWP. The nodular infiltrates increased significantly on follow-up films with the most recent exam on October 17, 2001 showed marked disease, mainly in the posterior and lateral portion of the mid and upper lungs. These are preferred areas for TB to attack while CWP typically involves central portion mid and upper lungs and does not involve periphery. Some of the nodules could be CWP but progression of CWP without massive unprotected ongoing exposure is very unusual. There are no large opacities. An exact diagnosis is needed because granulomatous disease like TB, sarcoid, histoplasmosis, and Wegener's, which can be cured or controlled. Granulomatous disease can explain all lung, pleural, and hilar disease.

At a deposition on June 5, 2002, Dr. Wheeler said that the change in profusion from 1986 (1/1) to 1994 (0/1) is not something that would be expected with pneumoconiosis, because that produces a stable pattern particularly without ongoing exposure. Granulomatous diseases can wax and wane. The progression in the chest x-rays from 1994 to 2001 is not expected in pneumoconiosis cases. In Dr. Wheeler's experience, "all the pneumoconiosis stabilize without further exposure," unless there is superimposed infection or development of a tumor. The only

changes that Dr. Wheeler sees in industrial patterns are pleural plaques from asbestos, which calcify over time. The term "progressive massive fibrosis" is "dangerous" because "it doesn't tend to progress without further exposure," "the masses are usually not massive," they are not all fibrosis, and if masses or lung patterns change over time a treatable disease like TB or cancer may be present. The changes in Mr. C.'s x-rays were not large opacities caused by coal dust exposure. The pattern is "more or less outside of the strike zone," it is largely in the lateral periphery of the lungs, an area typically attacked by granulomatous diseases, especially TB as well as others. Mr. C. may have simple pneumoconiosis, but the disease pattern is most likely granulomatous disease and not large opacities. There is no reason to believe that granulomatous disease is caused by coal dust exposure, but "it certainly isn't helped by it." The changes here could be explained by TB, sarcoid, histoplasmosis, or Wegener's.

Dr. David M. Rosenberg
(DX 31)

On May 15, 2002, Dr. Rosenberg, board certified in internal medicine, pulmonary disease, and occupational medicine, reviewed Mr. C.'s medical record. Mr. C. worked in the coal mining industry for over 30 years. He stopped working in 1993, with symptoms of shortness of breath reported before that. Mr. C.'s medical history included a myocardial infarction and underlying rheumatic heart disease. There were normal x-rays dating back to 1977, and in 1986 there was a question of pleural-based change and nodular densities. Over the last 14-15 years there have been progressive changes on Mr. C.'s chest x-ray. A needle biopsy of a peripheral based nodular abnormality in the upper right lung zone was negative. Mr. C.'s clinical condition worsened, noted by the progression of profusion on his chest x-rays, and he developed respiratory failure requiring mechanical ventilation. His pulmonary function tests were normal until last year, without evidence of increasing hypoxia with exertion. Mr. C.'s diffusing capacity was mildly reduced to 71%.

Based on his review of Mr. C.'s record, Dr. Rosenberg found that Mr. C. has interstitial opacities, many of which were described as nodular and present throughout the lungs but predominant in the mid and upper zones. These abnormalities could be related to the presence of the interstitial form of coal workers' pneumoconiosis. These changes have been associated with preservation of lung volumes and ventilatory function with increasing oxygenation after exercise. Thus, the findings are consistent with simple pneumoconiosis. Additionally, there is an onset of a peripheral based mass lesion in the right upper lung zone. Dr. Rosenberg agreed with Dr. Wheeler the complicated pneumoconiosis would progress from a central site peripherally, and not vice versa. Thus, the presence of complicated coal workers' pneumoconiosis is not verifiable based on the written reports. The weight loss is disturbing and the increased profusion ratings show the progression of Mr. C.'s interstitial changes. This progression occurred despite Mr. C.'s exit from the mines, which weighs against a diagnosis of coal workers' pneumoconiosis. Mr. C. probably has simple pneumoconiosis, but the progressive nature of Mr. C.'s disease leading to respiratory failure is not consistent with this diagnosis. The right upper lobe mass probably does not represent complicated pneumoconiosis.

Up until the last several years, Mr. C.'s ventilatory and gas exchange functions were preserved and he was not identifiably disabled. Of late he has developed respiratory failure and

his overall condition has deteriorated. His most recent pulmonary studies were performed with incomplete effort, so the actual degree of his impairment cannot be discerned. This impairment however, would not be related to progressive coal workers' pneumoconiosis, but probably relates to whatever is causing his progressive interstitial pattern. Carcinoma is a very concerning diagnosis, along with infectious concerns like tuberculosis. Further diagnostic testing such as an open biopsy should be done to establish the etiology of his respiratory problem.

Dr. Samuel V. Spagnolo
(DX 32)

On May 17, 2002, Dr. Spagnolo, board certified in internal medicine and pulmonary diseases, reviewed documents related to this claim, including objective medical evidence and medical opinions dated 1977 through 2002. Although Mr. C. has sufficient exposure to coal mine dust, he does not have consistent physical findings or laboratory evidence of any chronic lung disease arising from his coal mine employment. This opinion is supported by the negative physical exams, the pattern of radiographic findings from 1977 to 2001, and the valid normal lung function tests from 1994 to 2001. Although valid lung function tests were not available in 2000 or 2001, the 2001 arterial blood oxygen level was normal, which is a reliable indicator of global lung ventilation/perfusion matching, which indicates normal lung function. The radiographic changes may have begun in 1977, but were obvious to all reviewers in 1986. The changes remained relatively stable through 1995 and were worse in 2000 and 2001. Dr. Spagnolo had "great confidence in the thoughtful and well-reasoned radiographic interpretations by Dr. Wheeler," due to his extensive experience evaluating chest x-rays of individuals with occupational exposures, as well as TB, histoplasmosis, and sarcoidosis. Those conditions can lead to changes that less-experienced professionals can confuse with pneumoconiosis.

In Dr. Spagnolo's opinion, sarcoidosis best explains Mr. C.'s total clinic picture. It explains the relatively stable clinical course since 1986, normal lung function for many years, and the nodular pattern described on the x-ray interpretations, including the pleural involvement, lymphadenopathy, and the "not well defined other density in the right upper lobe." Mr. C. also has well-documented cardiovascular disease dating back to 1989, which may be contributing to the worsening radiographic changes and the worsening of his general medical condition. There is not enough objective evidence to justify a diagnosis of complicated coal workers' pneumoconiosis. Mr. C. is not totally and permanently disabled from a respiratory condition. His work capacity may be limited by other health factors. Mr. C. does not have a chronic restrictive or obstructive pulmonary impairment arising out of coal mine employment, nor has Mr. C.'s lung condition been aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

Dr. Kirk E. Hippensteel
(DX 32, DX 33)

On May 21, 2002, Dr. Hippensteel, board certified in internal medicine, pulmonary disease, and critical care, reviewed Mr. C.'s medical records. Dr. Hippensteel found that the data in the records was consistent with a diagnosis of simple coal workers' pneumoconiosis without any clinically significant pulmonary impairment on valid tests. Mr. C. has large lesions in both

upper lobes that do not look “at all typical” for large opacities from coal workers’ pneumoconiosis, and they have not been associated with any pulmonary dysfunction, as would be expected if Mr. C. had complicated pneumoconiosis. The records do not show definitive evidence about what these opacities are from. His recent, rapid change could be referable to neoplasia in his lungs. A rapid change in x-ray is against coal workers’ pneumoconiosis, which is usually more gradual. Mr. C. has the pulmonary function to return to his previous job in the mines. His cardiac disease appeared to impact his symptomatology, including shortness of breath, after Mr. C. has left the mines and had normal lung function. His arteriosclerotic heart disease is not related to his coal mine dust exposure. Although Dr. Scott suggested silicotuberculosis as a diagnosis, no such diagnosis was made from Mr. C.’s medical reports. As Dr. Wheeler suggested, there are other causes of granulomatous disease in the lungs, and Mr. C. needs to have his lungs investigated. Mr. C. would have been ill as a whole man, had he never developed coal workers’ pneumoconiosis.

At a deposition on May 30, 2002, Dr. Hippensteel said that he had reviewed Dr. Crisalli’s May 9, 2002 deposition, Dr. Rosenberg’s May 15, 2002 report, Dr. Spagnolo’s May 17, 2002 report, and Dr. Repsher’s interpretation of the May 17, 2002 chest x-ray. Mr. C.’s chest x-rays reveal that there is “certainly something going on in his chest that has created rapidly worsening status for him,” but the cause is unclear but thought not to be complicated coal workers’ pneumoconiosis. Mr. C. should have a CT scan or biopsy done. The radiographic progression from 1994 to 2000 is a much faster progression of the disease that one would expect in an active miner, let alone someone who is no longer exposed to the mine. It can progress over time, but the British physician Liddell has described the progression as something that happens one minor category over five years. Granulomatous disease can progress faster. The pulmonary function tests administered by Dr. Ranavaya in 2000 and Dr. Crisalli in 2001 were invalid. Dr. Crisalli’s 1995. Dr. Crisalli’s 1995 pulmonary function test and arterial blood gas study were normal. Dr. Crisalli’s 2001 study was invalid and understated Mr. C.’s lung function. Mr. C.’s 2001 blood gas study was normal. The 2000 blood gas study may have understated Mr. C.’s oxygen levels because Chapmanville is not at sea level; it is more than 640 feet above sea level. Overall, Mr. C. has a minimal diffusion impairment that has not changed as his x-rays have changed. That does not establish that Mr. C. has had no significant change in pulmonary function because there are no valid pulmonary studies since 1995. Complicated pneumoconiosis or massive fibrosis make enough progressive changes to pulmonary function that an associated pulmonary impairment is expected. Such impairment did not appear with Mr. C., and the x-ray abnormalities are not typical for complicated coal workers’ pneumoconiosis. The rapid change in x-rays is another factor against a diagnosis of complicated pneumoconiosis. Mr. C.’s health is generally deteriorating, as shown by his weight loss and anemia, which may be aggravated by the rapid process in his lungs. Mr. C. could have sarcoidosis, which can progressively change x-rays rapidly without significant changes to pulmonary function or gas exchange studies. Tuberculosis is not an expected diagnosis for Mr. C. because of the length of time that this has progressed and the lack of additional symptoms. From a radiologist’s viewpoint, the inclusion of tuberculosis was a generalization, a hallmark granulomatous disease. Dr. Hippensteel thought he had more information to base his opinion on than Dr. Scott, who did not have enough information to make a diagnosis of tuberculosis. There was sufficient evidence for a finding of simple coal workers’ pneumoconiosis, but the evidence weighed against a complicated pneumoconiosis. A PET scan would be helpful for diagnosis if a malignancy was present, but

Dr. Hippensteel thought Mr. C. had a nonmalignant inflammatory process in his lungs. Biopsy would be best. There is no evidence to say that Mr. C. does not have the pulmonary capacity to return to his job in the mines.

Dr. Zaldivar
(EX 1)

On February 23, 2005, Dr. Zaldivar conducted an assessment of Mr. C.'s pulmonary health. Mr. C. complained of shortness of breath spanning 15 to 20 years. He was on various medications, including nebulizers, which he sometimes used. Mr. C. smoked half of a pack per day from age 28 or 29 until 20 years ago, and worked in the coal mines for 30 years until 1994 when the mines closed down. Most of Mr. C.'s work in the mines was as a roof bolter which involved heavy lifting. Mr. C. said he had a negative tuberculosis test a few years ago. Upon physical exam, Dr. Zaldivar heard a loud bruit over the right carotid artery that he believed radiated from the heart, and also a murmur at the aortic area radiating over the entire chest. The lungs were clear to auscultation.

On April 27, 2005, Dr. Zaldivar performed a review of Mr. C.'s medical record, including reports and medical data from the 1980s to 2005. Mr. C. had a normal chest x-ray in 1977, and simple pneumoconiosis in 1986. Mr. C.'s "pneumoconiosis continued to progress as evidenced by the reading in many of the readers who graded at the upper range of profusion." Mr. C.'s lungs contained a mass that "has grown slowly over time according to these x-rays." The first apparent detection was 1995, and because Mr. C. is still alive 10 years later, "this mass does not represent a cancer." Additionally, it was "extremely unlikely" that the mass represents a scar from infection because they generally have centrally located calcifications. The most common lesion would be histoplasmosis, which is very easy to identify radiographically. Mr. C.'s "lesions contained some calcium, but they are scattered throughout the lesions, and unless they represented a rare tumor such as a hamartoma, the most logical conclusion is that these lesions are in fact slowly growing masses of complicated coal workers' pneumoconiosis." Mr. C.'s pulmonary function test was valid and showed a restrictive impairment, which is the "typical pulmonary functional abnormality in complicated coal workers' pneumoconiosis." The blood gases were "preserved at rest," but Dr. Zaldivar posited that with exercise the blood gases would deteriorate markedly because of Mr. C.'s diffusion abnormalities and the degree of restriction. Mr. C. also has valvular disease, but this is not causing the breathing test or radiographic abnormalities, and it is unrelated to his occupation. In summary, Mr. C. has simple and complicated pneumoconiosis, along with a disabling pulmonary impairment due to his coal mine employment. From a pulmonary standpoint, Mr. C. is incapable of performing any work at all.

Discussion

In ascertaining the cause of Mr. C.'s large pulmonary opacities or masses, Dr. Ranavaya and Dr. Zaldivar concluded Mr. C. had complicated coal workers' pneumoconiosis. Dr. Crisalli, Dr. Wheeler, Dr. Rosenberg, Dr. Spagnolo, and Dr. Hippensteel found insufficient evidence to conclude the masses were related to pneumoconiosis or Mr. C.'s long-term exposure to coal

mine dust. Due to this conflict in medical opinion, I must first assess the relative probative value of each respective opinion in terms of documentation and reasoning.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, I first consider Dr. Ranavaya's diagnosis. Essentially, based on the chest x-ray interpretation associated with his examination and Mr. C.'s long-term exposure to coal mine dust, Dr. Ranavaya concluded Mr. C. had complicated pneumoconiosis.

Dr. Ranavaya's assessment has diminished probative value due to documentation and reasoning shortfalls. Since Dr. Ranavaya relied solely on the results of his one evaluation, his opinion is not well documented in relation to the extensive medical evidence in the present claim. Further, as is readily apparent by the conflicting medical opinion in this case, radiographic evidence of large pulmonary opacities, standing alone, appears to be insufficient to identify the cause of the opacities such that other possible etiologies of cancer and infectious disease have been presented. Consequently, without further explanation, Dr. Ranavaya's complicated coal workers' pneumoconiosis finding based on one chest x-ray interpretation and Mr. C.'s work history loses some probative value due to incomplete reasoning.

Although the chest x-rays showed a large, Category C pulmonary opacity, Dr. Crisalli was unable to diagnose complicated coal workers' pneumoconiosis because he couldn't rule out malignancy based on Mr. C.'s extensive cigarette smoking history and recent weight loss. The physician also noted granulomatous disease could account for the mass in Mr. C.'s lungs. Additionally, Dr. Crisalli observed that the location of the lung mass was not consistent with complicated pneumoconiosis.

Due a documentation shortfall, Dr. Crisalli's findings have diminished probative value. Significantly, due to the date of his assessment, Dr. Crisalli was not aware of the two additional chest x-rays in February 2004 and 2005, the CT scan results from February 2005, the valid February 2005 pulmonary function test, and Mr. C.'s indication to Dr. Zaldivar that a TB test had been negative. Since the physician was unaware of this new information, he based his

conclusion on incomplete documentation and was not able to address whether the pattern of development of the opacities and their location further defined by the additional radiographic evidence, the valid pulmonary test showing a restrictive impairment, and Mr. C.'s TB test report would have assisted him in better identifying the cause of Mr. C.'s pulmonary opacities.

Although Dr. Wheeler did not specifically note large pulmonary opacities in Mr. C.'s lungs, he indicated the Mr. C.'s pulmonary disease most likely involved a granulomatous disease or TB based on the peripheral location of the pulmonary masses. He explained infectious diseases were more likely to develop in that area whereas coal workers' pneumoconiosis involves the central, not peripheral, mid and upper lungs. Dr. Wheeler also commented that while the nodules may involve coal workers' pneumoconiosis, "progression without massive unprotected ongoing exposure is very unusual" since "pneumoconiosis stabilizes without further exposure."

Because Dr. Wheeler relied on incomplete documentation and legally incorrect reasoning his opinion has diminished probative value. In terms of documentation, Dr. Wheeler was unaware of the significant additional radiographic evidence developed after he rendered his opinion, including the February 2005 CT scan which showed the conglomeration of interstitial nodules in both the upper and mid lung zones. In regards to reasoning, because he only considered radiographic studies, Dr. Wheeler did not discuss how other evidence from Mr. C.'s pulmonary examinations may or may not have supported his conclusion. Additionally, while he may have had a sufficient medical basis, Dr. Wheeler's comments about the stability of pneumoconiosis in the absence of continued coal mine dust exposure is legally deficient since it is inconsistent the regulatory definition of pneumoconiosis as a "latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c).

Dr. Rosenberg reasoned that the mass in Mr. C.'s right upper lobe was probably not complicated pneumoconiosis because of its peripheral location. Dr. Rosenberg also noted that the progression of Mr. C.'s disease after his exit from the mines weighed against a diagnosis of coal workers' pneumoconiosis.

For essentially the same documentary shortfalls noted above in Dr. Wheeler's opinion, Dr. Rosenberg's assessment loses probative value. Again, due to the date of his evaluation, Dr. Rosenberg was unaware of the additional radiographic evidence concerning the location of the pulmonary masses. Similarly, his observations concerning the ability of simple pneumoconiosis to progress after departure from coal mining is contrary to the regulatory definition of black lung disease.

Principally relying on Dr. Wheeler's assessment, Dr. Spagnolo also concluded that Mr. C. did not have complicated pneumoconiosis. Noting Mr. C. did not have a chronic restrictive or obstructive pulmonary impairment, Dr. Spagnolo concluded that sarcoidosis was the best explanation for Mr. C.'s pulmonary condition.

Since Dr. Spagnolo principally relied on Dr. Wheeler's radiographic interpretation and apparently the absence of valid pulmonary test results in 2000 and 2001, his opinion loses

probative value due to incomplete documentation. Specifically, Dr. Spagnolo was not aware of the additional 2004 and 2005 chest x-ray findings and the valid February 2005 pulmonary function test which established that Mr. C. was totally disabled by a moderate restrictive pulmonary impairment.

Dr. Hippensteel concluded the large lesions in Mr. C.'s upper lobes were not complicated pneumoconiosis for two reasons. First, no recent valid pulmonary test had established the presence of a pulmonary impairment such that Mr. C. had the pulmonary capacity to return to coal mining. The absence of a pulmonary impairment was important to Dr. Hippensteel because when complicated pneumoconiosis makes progressive changes to pulmonary function, "an associated pulmonary impairment is expected." Second, after eliminating tuberculosis due to the duration of Mr. C.'s disease, in light of the rapid radiographic changes and the absence of a pulmonary impairment, Dr. Hippensteel suggested Mr. C. had sarcoidosis. However, to further assess Mr. C.'s pulmonary condition, Dr. Hippensteel recommended a CT scan.

Since Dr. Hippensteel last considered Mr. C.'s pulmonary condition in May 2002, his opinion suffers a loss in probative value due to incomplete documentation. In light of Dr. Hippensteel's reasoning, this shortfall is particularly significant. Notably, the February 2005 valid pulmonary function study disclosed the pulmonary impairment that Dr. Hippensteel would expect to be associated with complicated pneumoconiosis. Additionally, as recommended, a CT scan was conducted in February 2005 and interpreted by Dr. Schlarb and Dr. Zaldivar as consistent with occupational pneumoconiosis and complicated coal workers' pneumoconiosis.

After reviewing Mr. C.'s employment and cigarette smoking histories and all the medical evidence developed through February 2005, Dr. Zaldivar concluded Mr. C. had complicated coal workers' pneumoconiosis. The physician opined the mass in Mr. C.'s lungs was not cancer because Mr. C. was still alive 10 years after the mass first appeared. Instead, Dr. Zaldivar found the radiographic evidence of slow progression of Mr. C.'s pulmonary masses consistent with complicated pneumoconiosis. Additionally, after noting Mr. C.'s negative TB test, Dr. Zaldivar determined Mr. C.'s large opacity was not related to an infectious lung disease because an infection would have left calcifications behind, which were not seen in Mr. C.'s lungs. Dr. Zaldivar also noted the development of Mr. C.'s restrictive pulmonary impairment, which disabled him from performing any work.

As the sole physician to consider all the medical evidence associated with Mr. C.'s duplicate claim and modification, including the most recent chest x-rays, CT scan, and valid pulmonary function test, Dr. Zaldivar's opinion is well documented and comprehensive. Having considered multiple possible etiologies for Mr. C.'s large pulmonary opacities, Dr. Zaldivar also presented a well reasoned medical assessment that Mr. C. has complicated coal workers' pneumoconiosis.

In summary, for various reasoning and documentation deficiencies, the medical opinions of Dr. Ranavaya, Dr. Crisalli, Dr. Wheeler, Dr. Rosenberg, Dr. Spagnolo, and Dr. Hippensteel have diminished probative value. The sole remaining assessment by Dr. Zaldivar that Mr. C. has complicated coal workers' pneumoconiosis is well documented, well reasoned, and most consistent with all the objective medical evidence in the record. Accordingly, I find the

preponderance of the probative medical opinion establishes that the large pulmonary opacities identified in the preponderance of the chest x-rays from 2000 through 2005 are complicated coal workers' pneumoconiosis.

Conclusion

Through the preponderance of chest x-rays from 2000 through February 2005, Mr. C. has shown the presence of large pulmonary opacities. Upon consideration of the other medical evidence, including a recent CT scan, I find that large opacity is present in Mr. C.'s lungs. Finally, having reviewed the other objective medical evidence and considered numerous medical opinions, I conclude based on the preponderance of the probative medical opinion, specifically, Dr. Zaldivar's findings, that the large pulmonary opacity is complicated coal workers' pneumoconiosis and related to Mr. C.'s to coal mine dust exposure.

Having proven that he has complicated coal workers' pneumoconiosis, Mr. C. has established that he is totally disabled by a pulmonary impairment through invocation of the irrebuttable presumption under 20 C.F.R. § 718.304 that he is totally disabled due to pneumoconiosis. In turn, my determination that the large pulmonary opacities in Mr. C.'s lungs since at least 2000 are complicated coal workers' pneumoconiosis which totally disables Mr. C. leads to the conclusion that a mistake of fact occurred during the adjudication of Mr. C.'s duplicate claim.³⁴ Due to that mistake of fact, under 20 C.F.R. § 725.310, modification of the denial of Mr. C.'s duplicate claim is warranted and hereby set aside. As result, Mr. C.'s duplicate claim is revived and I will now adjudicate that claim under the provisions of 20 C.F.R. § 725.309.

Issue # 2 – Material Change in Condition

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310 and above adjudication. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim which will be denied on the basis of the prior denial unless the claimant demonstrates a material change in condition under the provisions of 20 C.F.R. § 725.309, as interpreted by the BRB and federal courts of appeals.

To determine whether a material change in condition has occurred, an ALJ must consider the new evidence in the claim to determine whether the claimant has proven at least one of the elements of entitlement previously adjudicated against him. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd* 86 F.3d 1358 (4th Cir. 1996) (en banc).³⁵ I interpret the *Sharondale* approach to mean that the relevant inquiry in a material change case is whether evidence

³⁴When Judge Lesnick denied Mr. C.'s duplicate claim in January 2003 for failure to prove total disability, he obviously did not have the benefit of the 2004 and 2005 chest x-rays and CT scan, the valid February 2005 pulmonary function test, and Dr. Zaldivar's well documented and reasoned medical opinion.

³⁵Because Mr. C. last engaged in coal mine employment in West Virginia, this matter is under the jurisdiction of the Fourth Circuit.

developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

The adjudication of a duplicate claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to now prove that condition(s) of entitlement.

Mr. C.'s first claim was denied because although he showed that he had pneumoconiosis caused by his coal mine employment, he did not show that he was totally disabled due to pneumoconiosis. Accordingly, I will consider all the evidence in Mr. C.'s duplicate claim to determine if there has been a material change in condition.

Total Disability

As mentioned above, to receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability.³⁶ I have already found, based on the entire record of the duplicate claim, that Mr. C. has complicated pneumoconiosis. Consequently, I find that Mr. C. has proven total disability, through the irrebuttable presumption under 20 C.F.R. § 725.304, due to the presence of complicated coal workers' pneumoconiosis.

In turn, by proving total disability, Mr. C. has now established a material change in condition. As a result, under the provisions in 20 C.F.R. § 725.309, I will review the entire record to determine whether Mr. C. is able to prove all four elements necessary for entitlement of benefits under the Act; thereby establishing that he is totally disabled due to coal workers' pneumoconiosis.

Issue # 3 – Entitlement to Benefits

Again, as mentioned above, to receive benefits under the Act, Mr. C. must show by the preponderance of the evidence that he has pneumoconiosis, the disease arose at least in part out of coal mine employment, he has a total respiratory disability, and the total disability is due to pneumoconiosis.

³⁶20 C.F.R. §§ 718.204(b) and 718.304 (2001).

Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.³⁷ The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as “any chronic lung disease arising out of coal mine employment.”³⁸ The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”³⁹ As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),⁴⁰ and medical opinion (§ 718.202(a)(4)). Additionally, under the guidance of *Compton*,⁴¹ I must consider the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis.

As determined by Judge Miller in the first claim and Judge Lesnick, the presence of pneumoconiosis has been conclusively established. Upon review of the evidence in the first claim, coupled with the evidence in the second claim and modification, I find both the preponderance of chest x-rays and medical opinion clearly establishes that Mr. C. has pneumoconiosis. Under *Compton*, upon consideration of that evidence together, I reach the same conclusion. Finally, as discussed above, under the regulatory presumption regarding complicated pneumoconiosis in 20 C.F.R. § 718.304, Mr. C. has proven the presence of pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. C. must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. § 718.203(b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out

³⁷20 C.F.R. § 718.201(a) (2001).

³⁸20 C.F.R. §§ 718.201(a)(1) and (2) (2001).

³⁹20 C.F.R. § 718(b) (2001).

⁴⁰If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

⁴¹*See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

of such employment. As the parties stipulated, Mr. C. had at least 25 years of coal mine employment. As a result, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I have considered the entire record. Upon that review, I find a dearth of evidence demonstrating the opacities in Mr. C.'s lungs are unrelated to his long term exposure to coal mine dust while working as a roof bolter underground. As a result, the causation presumption under 20 C.F.R. § 718.203(b) has not been rebutted and I find that Mr. C.'s pneumoconiosis is due to his coal mine employment.

Total Disability and Total Disability Due to Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to coal workers' pneumoconiosis. Having invoked the 20 C.F.R. § 718.304 irrebuttable presumption and established causation under 20 C.F.R. § 718.203(b), Mr. C. has also proven these two necessary components for receipt of benefits under the Act.

CONCLUSION

Through the preponderance of recent chest x-rays, as confirmed by a recent CT scan and the preponderance of recent medical opinion, Mr. C. has established the presence of a large pulmonary opacity. Because the preponderance of the recent probative medical opinion further demonstrates the large opacity is complicated coal workers' pneumoconiosis, Mr. C. has invoked the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304. Through that invocation, Mr. C. has also demonstrated that modification of the denial of his second claim is warranted. Upon reconsideration of Mr. C.'s second claim, I conclude he has established that he has become totally disabled due to a pulmonary impairment and, correspondingly, shown a material change in condition since the denial of his first claim. Finally, based on the entire record, Mr. C. has proven that he is totally disabled due to coal workers' pneumoconiosis. Having proved each requisite element of entitlement, Mr. C. has met his burden of proof and his claim must be approved.

Date of Entitlement

According to the provisions at 20 C.F.R. § 725.503 (b) (2001), in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the coal miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the Claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*: "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989), where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is “first able to muster evidence of total disability is not necessarily the date of onset”).

Because the critical element of entitlement in Mr. C.’s case was the presence of a totally disabling pulmonary impairment, the essential inquiry for the date of entitlement centers on when Mr. C. was able to prove that he had complicated coal workers’ pneumoconiosis. Mr. C. was unable to prove total disability or complicated pneumoconiosis in his first claim. For the period between the denial of his first claim in January 1998 and August 2000, when Mr. C. filed his second claim, I also have insufficient evidence that Mr. C. was totally disabled due to coal workers’ pneumoconiosis. After Mr. C. filed his second claim, although the early chest x-rays were inconclusive or negative, most of the physicians who evaluated Mr. C. agreed that he had a large pulmonary mass in his lungs. Their medical dispute related to its etiology. Through the mistake of fact adjudication, I have now determined that the large pulmonary opacity is complicated pneumoconiosis which renders Mr. C. totally disabled. Since I can not definitively establish a period of time after Mr. C. filed his second claim when he did not have a large pulmonary mass or complicated coal workers’ pneumoconiosis, I find under 20 C.F.R. § 725.503(b) (2001) that Mr. C.’s date of entitlement is August 1, 2000.

Augmentation

The parties stipulated that Mrs. D.C. is an eligible dependent, so I find that Mr. C.’s black lung disability entitlement will be augmented for his spouse.

Attorney Fees

Counsel for the Claimant has thirty calendar days from receipt of this decision and order to submit an application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366 (2001). With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

ORDER

The claim of MR. R.C.C. benefits under the Act is **GRANTED**. BUFFALO MINING CO. is ordered to:

1. Pay Mr. R.C.C. all benefits to which he is entitled under the Act and Regulations. Benefits shall commence August 1, 2000, augmented for his spouse, Mrs. D.C.;
2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602(a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. R.C.C. for the period August 1, 2000 to the present;
3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and
4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608(b).

SO ORDERED:

A
RICHARD T. STANSELL-GAMM

Date Signed: April 19, 2007
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties
Certification:

Christopher A. Schlarb, MD

Certified by the American Board of Radiology in:

Diagnostic Radiology

American Board of Medical Specialties
1007 Church Street, Suite 404
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[HTTP://abms.org](http://abms.org)

Attachment No. 2

American Board of Medical Specialties
Certification:

Mohammed Iqbal Qasim Ranavaya, MD MS

Certified by American Board of Preventive Medicine in:

Occupational Medicine

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